

***United States Court of Appeals
for the Second Circuit***



AMICUS BRIEF

74-2138

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United States Court of Appeals

FOR THE SECOND CIRCUIT

Docket No. 74-2138

JANET GOTKIN and PAUL GOTKIN, individually and
on behalf of all persons similarly situated,

Plaintiffs-Appellants,

—against—

ALAN D. MILLER, individually and as Commissioner of
Mental Hygiene of the State of New York, MORTON B.
WALLACH, individually and as Director of Brooklyn
State Hospital, CHARLES J. RABINER, individually and
as Director of Hillside Medical Center, and MARVIN
LIPKOWITZ, individually and as Director of Gracie
Square Hospital,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

**BRIEF OF HOSPITAL ASSOCIATION OF
NEW YORK STATE, AMICUS CURIAE**

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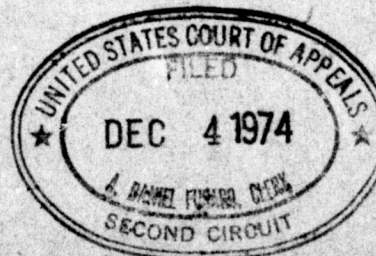


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Defendants-Appellees.

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BRIEF OF HOSPITAL ASSOCIATION
OF NEW YORK STATE, AMICUS
CURIAE

-----x
QUESTIONS PRESENTED

This brief amicus curiae is addressed to the follow-
ing questions:

1. Whether the policy of amicus' members, adopted
on an individual basis, providing for screening of a former

mental patient's records by a physician designated by such patient, is reasonable?

2. Whether the application of the medical screening policy by the individual member hospitals of amicus constitute action under color of state law?

3. Whether in view of the reasonableness of the hospitals' screening procedure, plaintiffs' constitutional rights have been violated?

STATEMENT OF THE CASE

This is an appeal from an order of the United States District Court for the Eastern District of New York entered on July 24, 1974, granting defendants' motions for summary judgment (Appendix, A-72-97).*

Plaintiffs-appellants (hereafter "plaintiffs") filed a complaint dated April 12, 1974, in the United States District Court for the Eastern District of New York, requesting injunctive and declaratory relief (Appendix, A-1-9). Plaintiff Janet Gotkin is a former mental patient who was denied direct access to the records compiled while she was hospitalized on several occasions between 1962 and 1970. She claims that she and her husband, plaintiff Paul Gotkin, have written a book concerning her hospital experiences, and she wishes to inspect these records in order

*Hereafter, references to plaintiffs' Appendix shall be "A- ."

to verify certain factual information concerning her hospitalizations (A-3-4).

Direct access to the records of Brooklyn State Hospital was denied the plaintiffs because of the medical screening policy adopted by the New York State Department of Mental Hygiene (A-20-22). Direct access to the records of Long Island Jewish-Hillside Medical Center and of Gracie Square Hospital was denied because of the medical screening policy adopted individually by these two hospitals (A-45-46, A-67).

Pursuant to this policy, a former mental patient, requesting his hospital records, is informed that although he may not have them directly, the hospital will make copies of them available to any physician he designates. In the exercise of his medical judgment, the physician may release as much of the records as the physician believes the former patient should see (A-20-22, A-45-46, A-67).

This appeal poses a challenge to a long standing and basic policy of New York's hospitals since most of them limit patients' direct access to records in the same manner as the defendants do. Neither in its intendment, nor its actual application does the policy purport to deny to any patient information concerning his hospitalization or treatment; on the contrary, the policy gives the patient

access to information contained in his records but only after his physician has reviewed the records and decided that they should be made available to the patient.

Plaintiffs' claim, which was properly rejected by the District Court, is that their constitutional rights are somehow violated by the screening procedures utilized by the hospitals in which plaintiff Janet Gotkin was treated. With the consent of all parties, the Hospital Association of New York State (hereafter the "Association") respectfully submits this brief amicus curiae in support of the policy of the hospital defendants-appellees (hereafter "defendants"), which as we show below is totally in accord with the constitutional standards enunciated by the Supreme Court.

INTEREST OF THE AMICUS

Founded in 1925, the Association is composed of approximately 300 non-profit voluntary hospitals and tax supported public and governmental hospitals in the State of New York. The purpose of the Association is to promote better hospital care for the people of the State. As part of its program, on appropriate occasions, the Association presents the views of its members to the Legislature, the Executive Department and, on occasion, to the Judiciary.

At the heart of the present controversy is the policy adopted by most of the Association's members which, with respect to medical records, interposes between the patient and the hospital a physician designated by the patient to review the patient's medical records before turning them over to the patient. This policy is not one of denial of a patient's right to information contained in the record. Rather, it reflects the firmly held belief that the best interests of the patient are served by a screening procedure which enables the patient to obtain the information that he reasonably needs to make informed decisions and, at the same time, protects him from the harm that could, in many cases, occur if direct access were permitted.

ARGUMENT

Point I

THE POLICY OF THE HOSPITALS TOWARDS A FORMER
PATIENT'S ACCESS TO HIS PSYCHIATRIC RECORDS
IS A REASONABLE POLICY.

Despite plaintiffs' contention that "the medical screening mechanism now proposed by defendants is . . . not a policy of general applicability" (Affidavit of Bruce J. Ennis, A-33), the procedures used by the defendants in this case are followed by almost all the members of the

Association. This medical screening policy is substantially the same as that described by Hayt, Hayt and Groeschel in their discussion of hospital policy in connection with a former patient's request for his medical records. When such a request is received, "the information will be given directly to the physician [who is treating him]." E. HAYT, L. HAYT & A. GROESCHEL, LAW OF HOSPITAL, PHYSICIAN AND PATIENT 1095 (3d ed. 1972)*. If the patient does not have a physician (or wants the information directly) and the physician in the hospital who had taken care of him is unavailable,

the patient is given an appointment with a physician on the administration staff of the hospital, who evaluates the inquiry and under appropriate circumstances provides the desired information to the patient, together with a proper interpretation. Id.

In addition to being the policy of the New York State Department of Mental Hygiene (Department Policy Manual, §2932), similar medical screening procedures are followed by such Federal agencies as the Veterans Administration and the Public Health Service.

*Copies of all articles, pamphlets, reports, legislative drafts and book excerpts, which are cited in this brief, appear in the Addendum hereto.

The Veterans Administration only allows a veteran access to information in his records "when such disclosure would not be injurious to the physical or mental health of the veteran" (38 C.F.R. §1.503 (1948)); and the determination of whether such information "will be prejudicial to the mental or physical health" of the veteran will be made by "the Chief Medical Director; Chief of Staff of a hospital; or the Director of an outpatient clinic." Id. §1.522 (1968).

The Public Health Service authorizes the officer in charge of a hospital or other Service facility to disclose to a patient "such clinical information [information obtained during the course of treatment, i.e. records] as such officer determines to be medically appropriate for disclosure." 42 C.F.R. §1.102(b)(1) (1956). However, the Public Health Service requires that "a reasonable showing of the need" for the information be made (id.); the hospitals in this case do not impose such a restriction.

If the screening procedures are reasonable in terms of medical records, we believe that they are vital in connection with psychiatric records. As the Court below observed: "Once again it should be emphasized that a mental patient's records are viewed in a more restrictive light than are the files of patients in general." 379 F. Supp. 859, 867-68

(E.D.N.Y. 1974).

That psychiatric records should be treated more carefully than ordinary medical records finds support in the proposed new Federal Rules of Evidence which contain a psychotherapist-patient privilege but not a physician-patient privilege. RULES OF EVIDENCE FOR UNITED STATES COURTS AND MAGISTRATES 504 (effective July 1, 1973).

A recent amendment to the New York Public Health Law provides, in part, that:

Upon the written request of any competent patient, parent or guardian of an infant, or committee for an incompetent, an examining, consulting or treating physician or hospital must release and deliver, exclusive of personal notes of the said physician or hospital, copies of all x-rays, medical records and test records regarding that patient to any other designated physician or hospital, provided, however, that such records concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant. N.Y. PUB. HEALTH LAW §17 (McKinney Supp. 1974).

The statute thus provides that medical records, excluding personal notes, are delivered to a physician or hospital designated by the patient, but not to the patient himself. The policy allows a physician or a hospital to

retain personal observations and does not permit a patient direct access to medical records. A fortiori, the policy adopted by the hospitals in New York, permitting all records to be delivered to the former patient's doctor, is certainly reasonable for psychiatric records.

- A. The Policy of the Hospitals Is Reasonable Because Disclosure of Some Information in the Former Patient's Record Could Jeopardize the Person's Current Mental Well Being.

The record compiled while a patient is receiving psychiatric care in a hospital contains entries that are more deeply personal than are ordinarily found in medical records, for it evidences the innermost thoughts and feelings of the patient, and of the patient's psychiatrist. One court expressed the relationship between patient and doctor in the following terms:

When a patient seeks out a doctor and retains him, he must admit him to the most private part of the material domain of man. Nothing material is more important or more intimate to man than the health of his mind and body. Since the layman is unfamiliar with the road to recovery, he cannot sift the circumstances of his life and habits to determine what is information pertinent to his health. As a consequence, he must disclose all information in his consultations with his doctor-- even that which is embarrassing, disgraceful or incriminating. ... there can be no

reticence, no reservation, no reluctance when patients discuss their problems with their doctors. Hammonds v. Aetna Casualty & Surety Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965).

Dr. Marvin Lipkowitz and Dr. Robert K. Match, in their affidavits below, describe the records as containing: ". . . the of-the-moment ruminations" of the psychiatrist (Affidavit of Dr. Lipkowitz, A-45-46) and "information about the patient which is received from third parties" (Affidavit of Dr. Match, A-60). The psychiatrist's observations may be as highly personal as those of the patient, consisting, as they might, of spontaneous emotional reactions. Similarly, the patient's family, friends and fellow patients may express deeply hidden feelings to the psychiatrist concerning the patient as well as themselves; secrets never revealed to the patient may be confided to the psychiatrist and then entered into the patient's record.

In their brief in this Court, plaintiffs argue that plaintiff Janet Gotkin "leads a normal, stable life with normal pressures. Under New York law, she is clearly presumed sane and competent." Brief for Appellants at 31. Nevertheless, there is always the danger that the expressions of emotion entered in the record could revive old feelings or reveal new information that might upset the current mental health of the former patient. The risk that

such an event could happen, possibly renewing the illness that had passed, is much too great when the alternative, a screening process, is such a sound guarantee that the patient will be protected. The deep commitment of a doctor to the health and well-being of his patient would be rendered meaningless if he had to provide direct access to records which might trigger a recurrence of the illness he had helped to cure.

Even some of the most ardent advocates of direct access to medical records recognize the fact that portions might be detrimental to the patient's health. Professor Hagman states, "Of course, if denial of access to the record is because access would cause harm to the patient, the patient should be denied access to whatever part would cause harm." Hagman, The Non-Litigant Patient's Right to Medical Records: Medicine v. Law, 14 J. FOR. SCI. 352, 362 (1969). Nathan agrees, even in a case where a former patient is merely trying to ascertain the identity of a negligent doctor in order to bring a malpractice action. Nathan, The Scope of Confidentiality Issues in the Modern Medical Setting (1970), excerpt in 8 HEALTH LAW PROJECT, MATERIALS ON HEALTH LAW 62, 70-71 (rev. ed. 1972). And Drs. Shenkin and Warner, in discussing a situation as upsetting as disclosure of psychiatric records, that of informing a patient that he has a terminal illness, counsel

"[c]ircumlocution on the record" to avoiding hurting the patient. Shenkin and Warner, Sounding Board-Giving the Patient His Medical Record: A Proposal to Improve the System, 289 N.E. J. MED. 688, 691 (1973).

Plaintiffs attempt to avoid this strong policy consideration against direct access by claiming that "[o]ther jurisdictions also recognize the rights of former patients of access to their records." Brief for Appellants at 19. However, two of the four cases cited to bolster their proposition explicitly hold that the harm disclosure might cause is justification for the courts' imposition of a screening process prior to release of the records. In Bishop Clarkson Memorial Hospital v. Reserve Life Ins. Co., 350 F.2d 1006, 1012 (8th Cir. 1965), the right of the insurance company to inspect was "qualified" by the condition that the patient not examine the records "where the bona fide and good faith judgment of the patient's doctor dictates and he certifies under oath that the records not be released to the patient or his authorized representative in the best interests of the [patient's] health." In Wallace v. University Hospitals of Cleveland, 170 N.E.2d 261, 261-62 (Ohio Ct. App. 1960), appeal dismissed, 172 N.E.2d 459 (Ohio 1961), the court modified the decision in the Court of Common Pleas by permitting the former patient-plaintiff inspection only "of such parts of such records, as in the discretion of the defendant, is proper

under the circumstances of the case, having in mind the beneficial interest of the plaintiff and the general purpose for which such records or any part thereof were kept and maintained . . ."

At other intervals in their brief, plaintiffs argue that commentators and various organizations have advocated that "records should be freely available." Brief for Appellants at 19, 59. Although plaintiffs can point to suggestions for greater accessibility of records, the call for freedom of access is often tempered by the judgment that more harm than good may come to the patient or former patient from such freedom.

Thus, plaintiffs invite attention to the recommendation of the American Hospital Association, in a working draft, "1. That statutes be enacted in all states recognizing the patient's right to access to the information contained in his medical record." American Hospital Association, Draft of Model Legislation on the Release of Medical Record Information at 3 (Sept. 10, 1974). However, following that statement is the second recommendation, which suggests:

2. That hospitals and other health care institutions be urged to establish policies providing for patient access to this information with interpretation by his physician or other designated person(s). Id. (emphasis added).

Clarifying the position of the American Hospital Association (hereafter "AHA") even further is A Patient's Bill of Rights, approved by the AHA in 1973. Right number 2 states that a patient has a right to complete information concerning his diagnosis, treatment and prognosis. However, Right number 2 also provides that someone else must receive this information "[w]hen it is not medically advisable to give such information to the patient." Denenberg agrees with the AHA: "The primary purpose of a hospital is to make sick people well and these rights are not intended to conflict with that goal in the slightest degree." Denenberg, Citizens Bill of Hospital Rights at 4 (1973).

Thus, the AHA has urged that caution be exercised in the area of granting access to medical records; withholding information when it is medically contraindicated and providing an interpretation of the record even when information may be released offer the protection a patient needs in confronting his records. We re-emphasize here the point made by the Court below: if the release of information from medical records should be made only with a screening mechanism, at least the same rule must apply to psychiatric records because the danger of harm to the patient is much greater.

At page 19 of their brief, plaintiffs cite the statement of the House of Delegates of the American Medical Association (hereafter "A.M.A.") to the effect that "[t]he patient has a recognized right to information from the records." A.M.A., Report X (adopted by the House of Delegates) 104, 107 (June, 1972). However, the rest of the sentence qualifies this "freedom of access": "at least to the extent that the information is necessary for the protection of his health interests or his legal rights." And the very next sentence provides:

Physicians also have recognized interests in hospital records to the extent that access to the records of a patient is necessary for the protection of the health interests of the patient. Id. (emphasis added).

The patient's right to information, as far as the A.M.A. is concerned, should be limited to protecting his health interest or his legal rights and is to be shared with his physician.

The A.M.A. is in the process of further articulating its position on a patient's access to his records. In a draft of a model Bill to Provide for Confidentiality of Medical Information, the section dealing with the right provides:

Section 5. (a) A physician, when forwarding an individual's confidential medical information to a third party on

authorization of such individual, may indicate which parts of such information, if any, are not to be disclosed to such individual. A.M.A., Draft of Bill to Provide for Confidentiality of Medical Information §5(a) (1974) (emphasis added).

Subsections (b) and (c) of Section 5 provide for access to and a copy of medical information which is in the possession of a third party, except, however, for those parts of such information "as the individual's physician may have indicated are not to be disclosed to the individual." Id. §5(b).

Another body which has expressed the belief that access to records should be limited only to information not detrimental to the patient is the Secretary's Commission on Medical Malpractice of the Department of Health, Education and Welfare. In its report, the Commission urged that legal representatives of the patient screen the material before turning it over to the patient. "The rationale of this approach is that although the hospital or physician could and would release the record directly to the patient in many situations, if there is doubt as to such release being in the best interest of the patient," then screening is necessary. SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, DEP'T OF HEW, MEDICAL MALPRACTICE 76 (1973) (hereafter "MEDICAL MALPRACTICE REPORT") (emphasis added). The Commission would substitute attorneys for

doctors, but the intent is the same: to protect the patient from disclosures which, in the representative's judgment, would be likely to affect him adversely.

Professor Fletcher expressly exempts psychotherapy from his doctrine of medical truth-telling. J. FLETCHER, MORALS AND MEDICINE (Chapter 2: "Medical Diagnosis: Our Right to Know the Truth") 62-63 (1954). He views diagnosis in psychiatric medicine and clinical psychology as opinions, not as truths, and thus not "owed to the patient." Id. at 63.

Two further points remain to be made on the question of harm to the former patient from disclosure of the contents of his psychiatric record. Plaintiffs contend that "the evidence is overwhelming that psychiatrists simply cannot predict behavior." Brief for Appellants at 57. Yet, the only support given for their argument are articles dealing with prediction of dangerous behavior. Although Dershowitz laments generally the acceptance of the medical model in the legal context, his focus is on the civil commitment procedure and the alleged inability of psychiatrists to predict whether an individual will be dangerous. Dershowitz, Psychiatry in the Legal Process: "A Knife that Cuts Both Ways," 51 JUDICATURE 370 (1968). It is also interesting to note that one article cited by plaintiffs

concluded that although there was no doubt room for improvement, "[i]t appears that dangerousness can be reliably diagnosed and effectively treated." Kozol, Boucher and Garofalo, The Diagnosis and Treatment of Dangerousness, 18 CRIME AND DELINQUENCY 371, 392 (1972).

Plaintiffs' contention that dangerousness is difficult to predict is sharply in dispute. Professor Rubin draws an important distinction between predictions of dangerousness and other predictions made by psychiatrists:

Treatment interventions depend on predictions of the likely consequences of such interventions. Such predictions are unavoidable for the psychiatrist, as indeed they are for anyone who proposes to treat another's illness. There is, however, another type of prediction, that of the likely dangerousness of a patient's future behavior. Rubin, Prediction of Dangerousness in Mentally Ill Criminals, 27 ARCH. GEN. PSYCHIATRY 397 (1972).

The second point that remains to be made is to re-emphasize the notion stated earlier, that a reasonable policy regarding psychiatric records includes a screening process. Plaintiffs cite Canterbury v. Spence to show that a patient has a right to expect disclosure from his physician. 464 F.2d 772 (D.C. Cir. 1972). This is not disputed. See, e.g., AHA, A Patient's Bill of Rights, Rights 2 and 3 (1973). Yet plaintiffs attempt to stretch the reasoning behind that case, which involves the right of a patient to give informed consent before treatment, to the medical records issue.

Beyond the fact that the Canterbury standard of disclosure has been followed very rarely (Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972)), its author, Judge Robinson, has continued to permit an exception to the physician's duty to disclose - the therapeutic privilege. A physician need not disclose when he deems it "medically warranted." Canterbury v. Spence, supra, at 789. This exception, of course, is potentially a large one:

The imposition of a duty of making disclosure is tempered by the recognition that there may be a situation where a disclosure should not be made because it would unduly agitate or undermine an unstable patient. Wilkinson v. Vesey, 295 A.2d 676, 689 (R.I. 1972).

On this point, see also Heidepriem and Resnik, Patients' Rights, 1973-74 ANN. SURV. AM. L. 87, 94.

If an exception to the disclosure rule exists for a physician when he predicts that it is medically inadvisable to disclose and to seek the patient's consent before he provides treatment, performs surgery, etc., a medical screening policy for information contained in the history of the treatment is a reasonable practice when the goal is to protect the patient from any jeopardy

to his present state of health.*

*In a report issued in 1973, in conjunction with the report of the Secretary's Commission on Medical Malpractice, a study prepared at the Georgetown University Law Center concluded that only six states have statutes which, either explicitly or implicitly, allow patients access to their hospital medical records. Helfman, Jarrett, et al., Access to Medical Records, in Appendix to MEDICAL MALPRACTICE REPORT 177, 181 (1973) (hereafter "Georgetown Law Center report"). In addition, the plaintiffs point to the new Hawaii statute which they claim "guarantee[s] all patients, including medical patients, access to hospital records." Brief for Appellants at 58. However, the Hawaii law expressly states that disclosure may only be made, which "upon proper inquiry, relat[es] to a particular patient and [which is] not clearly adverse to the interests of the patient . . ." HAWAII REV. STAT. §334-5 (Supp. 1973) (emphasis added); we submit that the Hawaii statute has authorized nothing other than the medical screening mechanism adopted by the individual member hospitals of amicus.

Among the state laws mentioned in the Georgetown Law Center report as providing access to the patient himself, Massachusetts explicitly exempts state mental health facilities from the patient access requirement. MASS. GEN. LAWS ANN. ch. 111, §70 (Supp. 1973). The same restriction concerning the records of mental health institutions applies to the Illinois statute, except that access to hospital records is only available in the first place to a former patient's attorney or physician. ILL. ANN. STAT. §§71, 72 (Supp. 1974).

New Jersey's statute makes no mention of access to a patient, providing merely that, without certain inapplicable exceptions, information from mental patients' records may be disclosed to a relative, friend, physician or attorney of the patient but only to the extent that such information relates to the "patient's current medical condition." N.J. REV. STAT. §30:4-24.3 (Supp. 1974) (emphasis added). In California, although a mental patient may designate persons to whom information or records may be released, such designation is subject to "the approval of the physician in charge of the patient" and it explicitly exempts "information which has been given to [a physician, psychologist, social worker, nurse, attorney, or other professional person] in confidence by members of a patient's family." CAL. WELF. & INST'NS CODE §5328 (West Supp. 1972).

Such states as Alaska, Kentucky and South Carolina have laws making confidential the records of patients who are hospitalized for psychiatric treatment. ALASKA STAT. ANN. §47.30.260 (1974); KY. REV. STAT. §210.235 (Supp. 1972); S.C. CODE ANN. §32-1022 (Supp. 1973). Only Connecticut appears to require that former patients be given direct access to their hospital records. CONN. GEN. STAT. ANN. §4-104 (1969).

B. The Policy of the Hospitals Is Reasonable Because Information Phrased in Technical Language May Be Misunderstood by the Individual.

A medical or psychiatric record contains "a wide variety of abbreviations and phrases that can be both confusing and unintelligible to the layman." MEDICAL MALPRACTICE REPORT at 76. For this reason, the Commission recommends that the patient "have guidance in understanding and using it." Id.

The medical screening policy is a reasonable solution to this problem because a doctor is the best interpreter of entries written in medical terminology. Rather than confronting a foreign document on his own, the former patient will receive a translation of the information into words he can understand. He can pose questions and have them answered, rather than worrying about material in the record which is not clear to him.

The danger of the patient's misunderstanding the record on his own is obvious. He may draw conclusions about people and about events in the past that are not real or justified. Such mistakes could lead to tragedy if the patient takes action based on his erroneous conception of a record entry's meaning. Not all misunderstandings are likely to be as humorous as the one Hagman points out: "an entry of 'patient s.o.b.' might be construed by the patient to mean something else than that he had shortness of breath."

Hagman, The Non-Litigant Patient's Right to Medical Records: Medicine vs. Law, 14 J. FOR. SCI. 352, 356 (1969).

The AHA pinpoints the fact that the record may be misunderstood by the patient as a rationale for its emphasis on the physician in interpreting the record for the patient. See AHA, Draft of Model Legislation on the Release of Medical Record Information at 3 (Sept. 10, 1974). Also, in explaining Right number 2 in A Patient's Bill of Rights, discussed supra, the AHA states that by interpreting the record for the patient, "the physician will be able to impart a great deal more useful information than the patient himself could glean on an uninstructed excursion into his own medical records." AHA, Explanation of Patient's Bill of Rights at 2 (emphasis added).

- C. The Policy of the Hospitals Is Reasonable Because Information in a Record May Contain References to and Statements by Other Individuals Which Should Remain Confidential to Protect Their Rights.

We have already discussed the potential harm that the revelation of statements of family, friends and fellow patients could do to the former patient. To allow the former patient to subsequently learn of such statements by means of his inspection of the record could cause embarrassment and anxiety to these other individuals as well. The statements were obtained under a mantle of confidentiality between the speaker and the psychiatrist; to now disclose the information violates that expectation.

The great danger, of course, is that if these relatives and friends, important sources of information for a psychiatrist, no longer believe that their statements will be protected from disclosure, they are not likely to come forward to share their insights, or, if they do, their observations may not be as complete or even as honest as they would be if the speaker knew they would not be revealed. Thus, the right of the former patient to access to his record may have the ironic result of making successful treatment more difficult, for without aid in the process of discovery that marks psychiatry's method of healing, mental illness may become a disease from which it is difficult to recover.

The medical screening mechanism, providing a doctor with the opportunity to delete references to these third parties before the former patient sees the record, is a reasonable means for resolving this problem. It protects their confidentiality without unduly infringing on the former patient's access to the record. For he is only being deprived of information that would violate the rights of others and, just as importantly, that would disappear from all records if disclosures of the references were made.

The Mental Health Legislative Guide Project, which is an activity of the Mental Health Law Project in Washington, D.C., being conducted under a cost-sharing contract with the National Institute of Mental Health, has added an optional provision to its Psychotherapeutic Confidentiality Legislation, which, in draft form at least, states, in part:

A psychotherapist may, to the extent he determines it necessary and appropriate, keep personal notes regarding a client wherein he may record (i) sensitive information disclosed to him in confidence by the persons on condition that such information would never be disclosed to the client or other persons, excepting, at most, other physicians or psychotherapists, (ii) sensitive information disclosed to him by the client that would be injurious to the client's relationships to other persons to disclose,
Mental Health Legislative Guide Project, Draft of
Psychotherapeutic Confidentiality Legislation
§18(a) (Oct. 14, 1974) (hereafter "Mental Health
Legislative Guide Project Draft").

Such a provision accomplishes the same result as the medical screening policy, but it is slightly more restrictive than the screening process described, supra, because, as another portion of Section 18 states, the author of the notes may only disclose them to a physician or psychotherapist who "is responsible for the treatment of the client." The screening policy of the hospitals would permit the records to be turned over to any licensed physician designated by the former patient. Yet, the consequence is the same: If material provided by third parties is confidential and would cause harm either to them, to the patient or to others if disclosed, no physician will allow its release. This is one of the purposes of the screening policy, and we believe it to be a reasonable policy.

- D. The Policy of the Hospitals Is Reasonable Because, If the Former Patient Is Allowed Direct Access to His Records, Psychiatrists Would Be Reluctant to Enter Certain Information in Records.

The importance of medical and psychiatric records should not be underestimated. "During the course of treatment,

there is no more important record than the hospital record" Fleischer, The Ownership of Hospital Records and Roentgenograms, 4 ILL. J. CONT. LEG. ED. 73 (1966).

In the case of Long Island Jewish-Hillside Medical Center:

These records contain, among other things, admission and discharge histories; diagnoses; observations; course of treatment; medication; internal memoranda; test results; and physical examination data. In the case of patients at the Hillside Division, these records also include such things as: psychological profiles; observations and conclusions of treating psychiatrists, psychologists and social workers; information about the patient which is received from third parties; and psychological evaluations of such third parties which are made by members of the Medical Center's staff. Affidavit of Dr. Robert K. Match (A-60).

In short, the hospital record is the compilation of everything the hospital learns about the patient. See HEALTH LAW CENTER, HOSPITAL LAW MANUAL (Chapter on "Medical Records" at 1) (1973) ("Medical records are maintained by hospitals to provide complete information about their patients"); Ownership of and Access to Hospital Records, 166 J.A.M.A. 796, 797 (1958) ("The primary purpose of these forms [the hospital record] is to make available at all times a complete, up-to-the-minute written record of the patient's condition and treatment").

The reason for having such complete information is communication - both to the individual who records an entry, as an aid to his memory, and to any other professional who is

providing care to the patient. The record is a "complex of communications between health professionals During the course of a particular hospitalization the record may include a wide spectrum of speculation and observation as the various members of the health team contribute thoughts and observations that lead eventually to the final diagnosis." MEDICAL MALPRACTICE REPORT at 76.

Because diagnosis and treatment involve "speculation and observation," the record must be a place where psychiatrists and other mental health professionals can set down theories as well as facts. Especially in psychiatry, emotional responses to patients and others constitute an important part of the treatment process. A psychiatrist must have the opportunity to freely record everything he believes relevant or else the record begins to lose its usefulness. A decision not to enter a thought may prevent a record from obtaining an important link. A nurse's determination, for example, that she will not quote the statement of the patient's daughter may rob the psychiatrist of a clue at some later time.

It is reasonable to assume that such hesitancy over entries in the record will occur if the former patient is given direct access to the record. Mental health professionals will fear breaching the confidentiality of their sources in addition to possibly causing an unfortunate

reaction on the part of the patient when he gets the record. Second thoughts about record entries will deprive the document of its ability to communicate. The end result will be a diminution in the effectiveness of treatment, for if the hospital record is the most important document in the hospital setting, an incomplete record will not communicate well.

The Mental Health Legislative Guide Project has proposed a solution: to allow a psychotherapist to keep "personal notes regarding a client wherein he may record:

(iii) the psychotherapist's speculations regarding possible causes of mental disorder, possible diagnoses or prognoses and possible treatments which he considers inadequately developed, confirmed or verified to warrant recording in the client's mental health record." Mental Health Legislative Guide Project Draft §18(a) (optional section).

The purpose of such a provision is to provide "a relief valve for psychotherapists to record items of information which they might otherwise trust to memory rather than risk its disclosure to insurers, employers, the client or his guardian or parents." Id. Comment on §18 at 44 (emphasis added).

The medical screening process has the same rationale. Knowing that before the record is released to the former patient, a doctor will make a judgment about the effect that disclosure would have on the people involved will free mental health professionals to record what they want, in the best

interest of the patient, his family and friends. The goal of effective treatment will not be threatened if the screening policy is allowed to continue.

- E. The Policy of the Hospitals Is Reasonable Because, If the Former Patient Is Allowed Direct Access to His Records, Hospitals Will Have to Expend Time and Money Going to Court to Prevent Access to Certain Material in the Record.

If the plaintiffs' reasoning in this case is adopted, all former mental patients will be entitled to their records "unless the hospital can demonstrate to a disinterested magistrate that there is good cause not to grant access." Brief for Appellants at 30. Such a decision would force the hospitals to become involved in litigation each time a professional determination was made that release of the complete record was medically inadvisable.

The consequences of plaintiffs' proposal could seriously disrupt the administration of a hospital. There are 119 psychiatric units in New York State, containing over 40,000 beds. Because of the recent policy of the New York State Department of Mental Hygiene (whose institutions contain seven times as many beds as private and general hospital psychiatric units combined) to discharge large numbers of its patients and because of the heavy turnover in psychiatric cases in general hospitals, approximately 100,000 patients have been discharged in each of the last two years. Reports of the Office of Statistical and Clinical Information Systems, New York State Department of Mental Hygiene (1974)

(unpublished). Over 60,000 of these patients discharged in 1972 and 1973 were from private and general hospitals.

To force a hospital to commence legal proceedings and apply for an injunction to prevent a former patient from gaining access to his record in even a small percentage of these cases would impose an extraordinary burden on the hospitals. Members of the staff would have to devote much of their time to testifying in court against medically unwarranted disclosure to the former patient. In order to handle this increased responsibility, the hospitals, in all likelihood, would have to hire added personnel. Beyond the fact that quality of treatment might suffer from the diversion of resources to administrative functions, the cost of treatment itself would have to increase to cover the cost of the new services and personnel.

In addition, our now heavily burdened court system would be forced to cope with still more litigation.* If only one percent of the patients discharged each year sought direct access to their medical records, we would have approximately 1,000 additional lawsuits a year. Each one of these could be a large case with expert testimony on both sides leaving

*It is noteworthy that a national conference, co-sponsored by the National Center for State Courts and the Federal Judicial Center, is being held early next year to examine methods for dealing with the growth in the number of cases reaching the state and Federal appeals courts throughout the country. "Program to Examine Appellate Caseloads," 172 N.Y.L.J. 4 (Dec. 2, 1974).

the ultimate determination to be made by a judge without medical training. A certain number of appeals could be expected so that the effect would be felt in our appellate courts also.

The present screening policy totally avoids such an unnecessary waste of judicial and medical manpower and money. Certainly, in the face of such a consequence if direct access is allowed, the policy of the hospitals in this case is reasonable.

Point II

THE POLICY OF THE INDIVIDUAL MEMBER
HOSPITALS OF AMICUS DOES NOT CONSTITUTE
ACTION UNDER COLOR OF STATE LAW.

Amicus, for its authorities in support of this Point, relies on and incorporates herein Point I of the Brief of the defendant Gracie Square Hospital. Amicus notes that the cases relied on involved voluntary hospitals and that although defendant Gracie Square is a proprietary hospital, perhaps further removed from state action, the screening policy of the voluntary hospital members of amicus cannot constitute state action.

The Association's member hospitals do not receive funding for, nor are they in any way regulated by, government as to their medical screening policy and procedures. Dr. Robert K. Match, Executive Vice President and Director of defendant Long Island Jewish - Hillside Medical Center, one of the member hospitals of amicus, states that its policy regarding patients' access to their hospital records was neither mandated by any governmental law, rule or regulation, nor conditioned on any grant of governmental funds (A-60-61). That statement is equally true for the voluntary hospital members of amicus. The state must be involved with the act of the hospital that caused the alleged injury; without such a

nexus, the hospital is not deemed to be engaging in action under color of state law. See, e.g., Powe v. Miles, 407 F.2d 73 (2d Cir. 1968); Barrett v. United Hospital, 376 F. Supp. 791 (S.D.N.Y. 1974); Mulvihill v. Julia L. Butterfield Memorial Hospital, 329 F. Supp. 1020 (S.D.N.Y. 1972).

Point III

SINCE THE HOSPITALS' PROCEDURE IS A REASONABLE ONE, THERE CAN BE NO DEPRIVATION OF PLAINTIFFS' DUE PROCESS RIGHTS.

The brief of the defendant Long Island Jewish - Hillside Medical Center has shown that plaintiffs have no liberty or property interest at stake insofar as hospital records are concerned.

However, assuming arguendo that the former patient has a constitutional right of liberty or property in her psychiatric records and assuming further that the actions of either defendant Long Island Jewish - Hillside Medical Center, a voluntary hospital, or the actions of defendant Gracie Square Hospital, a proprietary hospital, are found to constitute action under the color of state law, even then the plaintiffs have not been deprived of liberty or property without due process.

A. The Standard to Be Applied in this Case Is the Rational Basis Test.

A long line of Supreme Court decisions has established that the standard to be applied in determining whether the plaintiffs have been deprived of liberty or property without due process is the "rational basis" test. See, e.g., Richardson v. Belcher, 404 U.S. 78 (1971); Flemming v. Nestor, 363 U.S. 603 (1960); Williamson v. Lee Optical Co., 348 U.S. 483 (1955); Nebbia v. New York, 291

U.S. 502 (1934). As the Court stated in Richardson, "If the goals sought are legitimate, and the classification adopted is rationally related to the achievement of those goals," then there is no violation of the due process clause. 404 U.S. at 84 (emphasis added).

The "rational basis" test came into existence when the Supreme Court eschewed its previous practice of close examination of state laws regulating economic matters and chose the alternative of permitting states to act as they desire in the business area as long as the action is "rationally based and free from invidious discrimination." Dandridge v. Williams, 397 U.S. 471, 487 (1970). The test has been applied in the most "basic matters of human decency and welfare. The constricted test in this forum is one of minimal rationality." Snell v. Wyman, 281 F. Supp. 853, 863 (S.D.N.Y. 1968), aff'd, 393 U.S. 323 (1969) (welfare recipients). See also Richardson v. Belcher, 404 U.S. 78, 81, (1971) (a case involving social security recipients, where the Court said that regulation "in the area of social welfare" is consistent with both the due process and the equal protection clauses if it is rationally based).

B. Under the Rational Basis Test, the Policy of the Hospitals Does Not Deprive the Plaintiffs of Due Process.

In Point I hereof we have demonstrated that the screening policy in use by the hospitals is an eminently reasonable one.

Because the policy is so plainly reasonable, plaintiffs cannot rationally claim to have been deprived of due process merely because Mrs. Gotkin has refused to designate a physician who could review her hospital records.

Further, the plaintiffs themselves acknowledge that not all former patients should get their records. Brief for Appellants at 30. They admit that a showing can be made before "a disinterested magistrate that there is a good cause not to grant access." Id. Surely the hospitals cannot be said to have deprived the class of former patients of their liberty or property when the plaintiffs concede that not all former patients should have access to their records.

Finally, if a former patient in a state institution believes that he should have access to his records despite a hospital's refusal to accord it, the former patient has recourse

to a legal proceeding to enforce his claim. N.Y. MENTAL HYGIENE LAW §15.13(c)(1) (McKinney Supp. 1974) (clinical records shall not be released to any person, except, among other methods, "pursuant to an order of a court of record"). Therefore, the former patient is not deprived of a right to judicial review.

In sum, the hospitals' policy is designed to protect the class of former patients who desire to have the information contained in their records. In meeting this goal, the hospitals' procedure is to provide such information as is found in the records to any physician chosen by the former patient; it is left to the physician to make his own determination of what is best for his patient. And the former patient of a state institution, if dissatisfied with a refusal to grant access, can always seek redress by application to the court.

Under these circumstances, it is clear that the hospitals' policy is rationally related to the goal it is aimed to achieve and that the policy by no means discriminates against this class of former patients. The plaintiffs cannot show that this procedure deprives them of the right to liberty or property without due process.

CONCLUSION

For the foregoing reasons, amicus submits that the judgment below should be affirmed.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Index No. 74-2138

Janet Gotkin and Paul Gotkin, individually
and on behalf of all persons similarly
situated,

Plaintiff

against

Alan D. Miller et al.,

Defendant

**AFFIDAVIT OF SERVICE
BY MAIL**

STATE OF NEW YORK, COUNTY OF New York

SS.:

The undersigned being duly sworn, deposes and says:

*Deponent is not a party to the action, is over 18 years of age and resides at
15 Brompton Road, Garden City, New York 11530*

That on December 4th

19 74 deponent served the annexed

*Brief of Hospital Association of New York State, Amicus Curiae
on Lippe, Ruskin & Schlissel, P.C.*

attorney(s) for Defendants-Appellees

in this action at 114 Old Country Road, Mineola, New York 11501

*the address designated by said attorney(s) for that purpose by depositing a true copy of same enclosed
in a postpaid properly addressed wrapper, in ~~a post office~~ official depository under the exclusive care
and custody of the United States Postal Service within the State of New York.*

*Sworn to before me this 4th day
of December, 1974*

Sandra Hile

The name signed must be printed beneath

Sandra Hile

Philip Castellano Jr.

PHILIP CASTELLANO JR.
NOTARY PUBLIC, State of New York
No. 52-4504329

Qualified in Suffolk County
Cert. filed in New York County
Commission Expires March 30, 1975

Index No.

against

Plaintiff

Defendant

**ATTORNEY'S
AFFIRMATION OF SERVICE
BY MAIL**

STATE OF NEW YORK, COUNTY OF

ss.:

*The undersigned, attorney at law of the State of New York affirms: that deponent is
attorney(s) of record for*

That on

19

deponent served the annexed

on

*attorney(s) for
in this action at*

*the address designated by said attorney(s) for that purpose by depositing a true copy of same enclosed
in a postpaid properly addressed wrapper, in—a post office—official depository under the exclusive care
and custody of the United States Postal Service within the State of New York.*

The undersigned affirms the foregoing statement to be true under the penalties of perjury.

Dated

The name signed must be printed beneath

torney at Law

Copy received
Goldwater + Flynn
by Henry Feraish.
1:40 PM Dec. 4, 1974

Copy received
Christopher A. Hansen
counsel for plaintiffs
Dec. 4, 1974

COPY OF THE WITHIN PAPER
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DEC 4 1974

NEW YORK CITY OFFICE
James Hoffmann
ATTORNEY GENERAL